Mental Health System Transformation Initiative Implementation

Washington State
Department of Social & Health Services

Winter Forum

January 16, 2007

Agenda For Today

Morning:

1. Background and brief overview of STI projects
2. Overview of STI Timeline
3. Involuntary Treatment Act

Afternoon:

1. PACT Update
2. Benefits Package Study
3. Housing Action Plan

Background

2006 Legislation & Budget Initiatives

- Clarified roles of State & RSNs related to community and state hospital care
- Time limited investment in State Hospital capacity to deal with inpatient access issues
- Investment in enhanced community resources to reduce reliance on state hospitals
    - PACT
    - Funding for PALS Residents
- By January 2008, requires RSNs to pay for individuals at PALS
- Long term planning

Key Provisions (cont'd)

Community Resources

- Funding for PACT & other Expanded Community Services
  - Development funds FY 07
  - Operational Funds FY 08
  - Contract for Training & TA- WIMIRT

Key Provisions (cont'd)

Community Resources

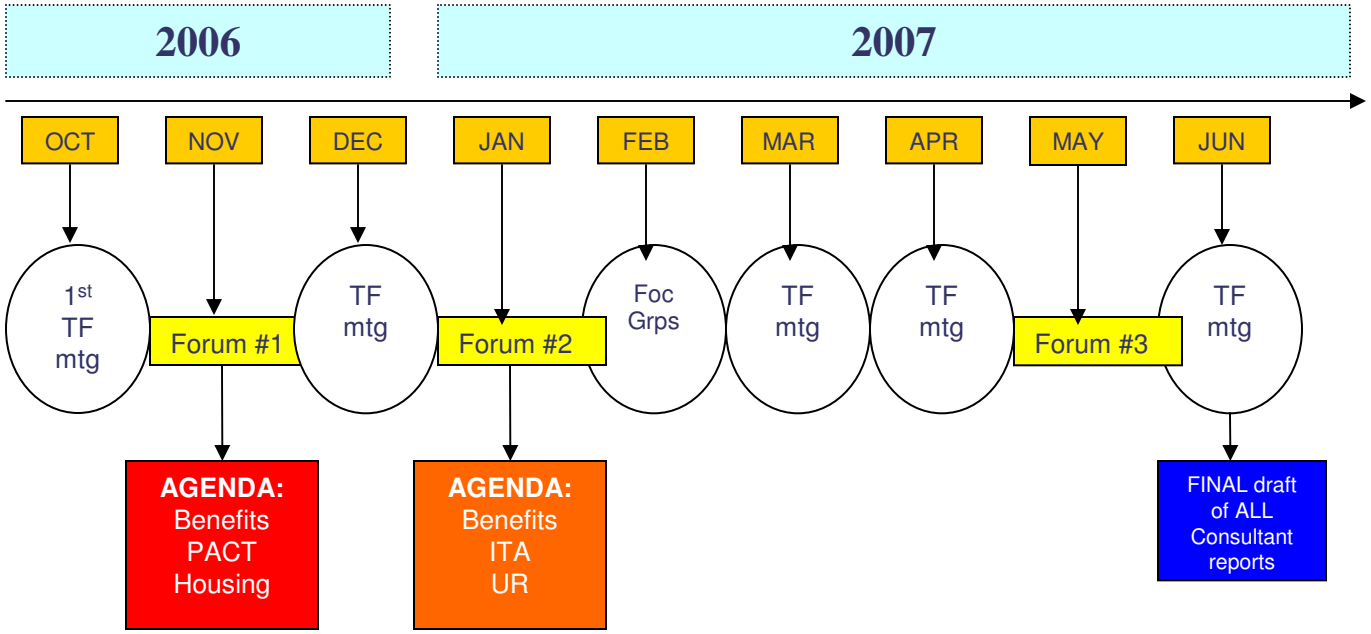
- Long Term Planning - Consultant Contracts
  - Benefits Package/ Rates- TriWest
  - Involuntary Treatment Act- TriWest
  - Mental Health Housing Plan- Common Ground
  - External Utilization Review- TBD

STI Implementation

Process

- Consultants For Each Project Initiative
- Standing Representative Task Force
  - 35-40 members from variety of interested parties
  - Monthly meetings beginning in Oct 06
  - Consumer, family, and advocate representatives
  - Focus groups as needed
- Community Forums- approximately 150 people
  - November 06, January 07, and May 07
- Tribal Roundtable/s- Feb 2007
- Focus Groups- by consultants as needed
- STI Web Site

STI Task Force & Community Forum Timeline



Washington State System Transformation Initiative: *Review of Involuntary Treatment Laws*

January 16, 2007

Jenifer Urff, J.D.
Advocates for Human Potential, Inc.

Project Team for Review of Involuntary Treatment Laws

- Andy Keller, Ph.D., Project Director (TriWest)
- Jenifer Urff, J.D. (AHP)
- Alan Marzilli, M.A., J.D. (AHP)
- Jenna Ichikawa, M.P.A. (TriWest)

Consultant Background

- Advocates for Human Potential, Inc. (AHP)
  - New Freedom Initiative/Olmstead Initiative to promote community integration
- National Association of State Mental Health Program Directors (NASMHPD) (1998-2003)
  - Government Relations
  - Legal Division/Forensic Division
    - Kansas v. Crane
    - Kendra's Law
    - MacArthur Study on Mental Illness and Violence
    - Olmstead v. L.C.

Overview of Project: Review of Involuntary Treatment Laws

- Review specific provisions in State involuntary treatment statutes
- Compare specific provisions with other states' approaches
- Identify strengths, challenges, and options for reform

Context and Focus for Review of Involuntary Treatment Laws

- MHD's desire to create a recovery-focused, resiliency-based system of care
- Specific focus on civil commitment issues affecting community and State hospital utilization
- Relevant statutes
  - RCW 71.05 (Adults)
  - RCW 71.34 (Children)
  - RCW 10.77 (Forensic) as it applies to misdemeanor patients

Context and Focus for Review of Involuntary Treatment Laws

- Utilization of state hospitals:

  26.15 beds per 100,000 population (2005)
  - National average: 17.12 beds per 100,000
  - Comparisons:
    - Oregon: 20.75 beds
    - California: 13.95 beds
    - Pennsylvania: 18.61 beds
    - Arizona: 5.33 beds

  Source: SAMHSA Uniform Reporting System (2005)

Context and Focus for Review of Involuntary Treatment Laws

- High rates of involuntary commitment to state hospitals

	% patients voluntarily committed	% patients involuntarily committed	% forensic patients
Washington	10	60	30
National Median	10	50	34

  - Only 11 (of 41 states) had a higher percentage of involuntary commitment

Source: NASMHPD Research Institute, Inc. (2006)

Process for Review of Involuntary Treatment Laws

- Literature review/legal research/data collection (now underway)
- Stakeholder input (now underway)
  - Task Force meeting (December)
  - Community Forum to collect information from multiple stakeholders (January)
  - Focus groups as needed (December – March)
  - Key informant interviews (January – March)
    - State leaders: consumers, families, community providers, state hospitals, law enforcement, courts, advocates
    - Solicit input from all parts of the State
  - Interviews with national experts

Process for Review of Involuntary Treatment Laws

- Comparisons with other States
  - Geographic similarities
  - Similar financing structures
- Reports
  - Preliminary Report (February, 2007)
    - Define scope of review
    - Articulate questions/issues presented
    - Discuss literature review
    - Identify states for comparison study
  - Draft Final Report (May, 2007)
  - Final Report (June, 2007)

Legal Basis for Involuntary Treatment

- Police power/public safety:
  - Other examples include compulsory vaccinations or quarantines
- *Parens patriae*
  - "Parent of the country"
  - State can act as guardian for individuals who lack capacity to take care of themselves

Legal Basis for Involuntary Treatment

- Involuntary confinement is a significant limitation on an individual's liberty interests and must meet constitutional standards:

> "[A] State cannot constitutionally confine … a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

O'Connor v. Donaldson, 422 U.S. 563 (1975)

Legal Basis for Involuntary Treatment

- ***U.S. Supreme Court***: In order to be involuntarily committed, an individual must:
  - Have a mental disability
  - Pose a substantial threat of serious harm to oneself or others

Washington's Involuntary Treatment Law

- Commitment ***criteria***:
  - Mental disorder *and*
  - Likelihood of serious harm *or*
  - Gravely disabled
- Commitment ***process***:
  - Initial 72-hour detention for evaluation by Designated Mental Health Professional (DMHP)
  - 14-day commitment
  - 90- or 180-day commitments

Washington's Involuntary Treatment Law and Key Policy Issues

- "Mental disorder"
- "Gravely disabled"
- Process for initiating and implementing involuntary civil commitments in Washington State, especially for individuals who are arrested for misdemeanor crimes and are found to be not competent to stand trial ("forensic conversion")

Key Policy and Legal Issues: Definition of Mental Disorder

Washington:

"Mental disorder" means ***any organic, mental, or emotional impairment*** which has ***substantial adverse effects*** on a person's ***cognitive or volitional*** functions

WASH REV. CODE 71.05.020(22)

Key Policy and Legal Issues: Definition of Mental Disorder

Maryland: "Mental disorder" means

- A behavioral or emotional illness that results from a ***psychiatric or neurological disorder***
- Includes a mental illness that so ***substantially impairs the mental or emotional functioning*** of an individual as to make care or treatment necessary or advisable for the welfare of the individual or for the safety of the person or property of another
- Does not include mental retardation

MD. CODE ANN., HEALTH-GEN. § 10-101(f).

Key Policy and Legal Issues: Definition of Mental Disorder

Mississippi: "Mentally ill person" means any person who:

- Has a ***substantial psychiatric disorder*** of thought, mood, perception, orientation, or memory
- Which ***grossly impairs*** judgment, behavior, capacity to recognize reality, or to reason or understand

MISS. CODE ANN. § 41-21-61(e)

Key Policy and Legal Issues: Definition of Mental Disorder

Ohio: "Mental illness" means:

- A ***substantial disorder*** of thought, mood, perception, orientation, or memory that
- ***Grossly impairs*** judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life

OHIO REV. CODE ANN. § 5122.01(A)

Key Policy and Legal Issues: Definition of Gravely Disabled

Washington: "Gravely disabled" means a person is:

- In danger of ***serious physical harm*** resulting from a failure to provide for his or her essential human needs of health or safety; or
- Manifests ***severe deterioration in routine functioning*** evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions; and
- Is not receiving ***such care as is essential*** for health or safety.

WASH REV. CODE 71.05.020(16)

Key Policy and Legal Issues: Definition of Gravely Disabled

Arizona:

"Gravely disabled" is a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to ***serious physical harm*** or ***serious illness*** because he is ***unable to provide for his basic physical needs***

ARIZ. REV. STAT. § 36-501(16)

Key Policy and Legal Issues: Definition of Gravely Disabled

Pennsylvania: Permits involuntary commitment where there is a:

- ***Clear and present danger*** to self or others, including inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety; and
- ***Reasonable probability*** that ***death, serious bodily injury or serious physical debilitation*** would ensue ***within 30 days***

50 PA. CONS. STAT. ANN. § 7301

Key Policy and Legal Issues: Forensic Conversion

- Forensic Conversion Process: Individuals who are charged with a misdemeanor crime may be subject to a forensic evaluation under RCW 10.77.
  - If the person is not competent and has a history of violent acts, he or she ***must*** undergo a competency restoration process (14-29 days)
  - If restoration is not successful, judge ***must*** order 72-hour evaluation for civil commitment (currently done at state hospitals)
  - If petition for civil commitment is filed, initial period of civil commitment is 90 days

Key Policy and Legal Issues: Forensic Conversion

Stakeholder concerns:

- Steep increase in forensic conversions, esp. in King County
- Time periods for competency evaluations and restoration period can result in unnecessary waiting in jails (separate effort to review)
- Difficulty in determining prior acts of violence
- Mandatory restoration and evaluations; no judicial discretion
- Location of 72-hour evaluations
- Perception of likelihood by DMHPs to petition for involuntary commitment may contribute to overuse

Other Issues Related to Review of Involuntary Treatment Laws

- State hospital utilization and lengths of stay
- Least restrictive alternatives/community service capacity
- Parent-Initiated Treatment and age of consent
- Involuntary medications
- Role of prior history in determining dangerousness
- Implications for tribal governments
- Role and potential of advance directives

Preliminary Observations

- 12/21 Task Force meeting:
  - Consensus: Real issue is availability of community-based alternatives
  - Broad definition of “mental disorder” may lead to inappropriate placement in state hospitals (esp. for people with TBI, DD, other dementia)
  - Definition of “gravely disabled” is less important than how it is interpreted and applied
  - Analysis: 71.05 and 10.77 must be reviewed together, as changes to one statute will affect application of the other

Questions

Policy Objectives of Involuntary Treatment Laws:

- Protecting people with mental illnesses and others from harm
- Protecting individual rights and personal liberty
- Providing access to an appropriate continuum of care that supports recovery and resilience
- Promoting community-based services and reducing reliance on inpatient care
- Facilitating efficient use of public resources

Questions

1. Washington State permits civil commitment of a person with mental illness if he or she is "gravely disabled," which is defined in statute as a person who is "in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety" or manifesting "severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety."
   - What about this definition works to support the policy objectives of this review?
   - What doesn't work?
   - What would you change and why?

Questions

2. Washington State's involuntary treatment law defines "mental disorder" to include "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions."
   - What about this definition works to support the policy objectives of this review?
   - What doesn't work?
   - What would you change and why?

Questions

3. In Washington State, the age at which a person can voluntarily seek, request, or terminate inpatient mental health treatment is 13. However, a minor may be admitted into an inpatient or evaluation and treatment facility for an evaluation at the initiation of his or her parent. If the professional conducting the evaluation determines that inpatient treatment is medically necessary, a minor may not be discharged based solely on his or her refusal to accept treatment.
   - What about these laws work in the best interests of children and families?
   - What doesn't work?
   - What would you change and why?

Questions

4. What other issues or concerns related to Washington's involuntary treatment laws are important to you?

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Washington State
System Transformation Initiative

PACT Implementation
Community Forum Update

January 16, 2007

Maria Monroe-DeVita, Ph.D.
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Update Overview

1. Update on current PACT implementation processes
2. Feedback from the Fall Community Forum
3. Initial next steps for integration of Forum feedback into implementation processes

Current WA PACT Implementation Efforts

1. Assembled a committee and process for reviewing RSNs' implementation plans
2. Developing feedback reports to identify strengths, challenges, and recommendations
3. Meeting with RSNs to begin collaboratively identifying initial training and technical assistance needs
4. Planning for RSN training in February
5. Developing a training and TA plan for roll-out in February

Feedback from Fall Community Forum

Three questions posed:

1. What outcomes are most important for PACT?
2. What concerns should we be watching for?
3. How do we ensure a person-centered, recovery-oriented model within the framework of PACT?

#1: What outcomes are most important for PACT?

- Reduction in criminal justice involvement
- Reduction in other high acuity services
- Increase in/better housing
- Community and social integration
- Increase in employment
- Consumer satisfaction and quality of life
- Consumer engagement in recovery
- Graduation from PACT

#2: What concerns should we be watching for?

- Not recovery-oriented
  - Goals identified by team vs. consumer
  - Coercive; not truly voluntary
  - Paternalistic/perpetuates learned helplessness
- Lack of an individualized approach
  - Service array is too uniform
  - Assumption of one size fits all
- External factors may prevent success
  - Not enough housing
  - Lack of secured, ongoing funding

#2: What concerns should we be watching for?

- Program fidelity–some want it, some don't
- Medical model vs. addressing range of needs and preferences
- Lack of cultural competence
- Un-integrated peer specialists
- Not available statewide
- Concerns about who PACT serves

#3: How do we ensure a person-centered, recovery-oriented model?

- Active consumer participation
  - Within PACT:
    - Recovery planning
    - Consumer preferences, goals, choices
    - Direct service provision
  - Outside of PACT:
    - Planning
    - Evaluation
    - Monitoring

#3: How do we ensure a person-centered, recovery-oriented model?

- Team is person-centered in everything they do:
  - Recovery Planning; WRAP
  - Ensure goals are consumer's not the team's
  - No "one size fits all" goals
  - Services are driven by consumer choice
  - Strengths-based approach
  - Consumer choice in working/not working with particular team members

#3: How do we ensure a person-centered, recovery-oriented model?

- Educate, empower, train consumers in recovery
  - Assertiveness skills in voicing preferences, choices
  - Importance of assuming responsibility for own recovery
  - Encourage, coach consumers in making own decisions/choices and the positive impact for them

#3: How do we ensure a person-centered, recovery-oriented model?

- Create a culture of recovery with PACT staff
  - Hire staff who espouse recovery values
  - Train staff in recovery
  - Ensure that peer specialists are fully integrated and provide cross-training
  - Educate the community about recovery
  - Adopt SAMHSA's National Consensus Statement on Mental Health Recovery

#3: How do we ensure a person-centered, recovery-oriented model?

- Develop mechanism for ongoing team monitoring & accountability
  - Evaluate whether the team is being person-centered and recovery-oriented
  - Examine consumer satisfaction and dissatisfaction
  - Evaluate quality of life indicators

Places of Impact on Next Steps

- Contract requirements with RSNs
- Washington State PACT Program Standards
- Training and Technical Assistance (TA)
- Program Evaluation:
  - Program Fidelity Assessment
  - Outcome Evaluation

Next Steps

- Prioritize recovery training and ongoing education for all PACT staff and consumers *(training & TA, contract)*
- Ensure that all clinical training in evidence-based approaches is person-centered & recovery-oriented *(training & TA, contract)*
- Promote and monitor full integration of peer specialists on the team; provide mechanism for ongoing mutual support
  (training & TA, Standards, evaluation)

Next Steps

- Support local PACT Stakeholder Advisory Group membership, participation, and ongoing feedback *(Standards, contract, training & TA)*
- Incorporate assessment of recovery processes into fidelity tool *(evaluation)*
- Evaluate consumer recovery as part of outcome assessment *(evaluation)*
- Ensure psychiatric rehabilitation service approaches *(Standards, training & TA, evaluation)*

Next Steps

- Ongoing monitoring of appropriate authorization, admission, and prioritization processes *(Standards, evaluation, TA, contract)*
- Staff training in cultural competence; Ongoing monitoring of Culturally and Linguistically Appropriate Services (CLAS) *(training & TA, Standards, contract)*
- Training and TA in housing acquisition and retention *(training & TA, contract)*

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Mental Health Housing *ACTION* Plan

MHD Contract Deliverables

- Data collection/preliminary report Jan ’07
- Draft Housing Action Plan April ’07
- Final Report June ’07
- Technical assistance Feb – June ’07

Summary
Input From November Community Forum

What Housing Supports?

- Peer support / recovery strategies
- Landlord support/education
- Onsite services in community based housing
- Discharge planning: hospitals, jails, prisons
- Housing and service provider collaboration
- More resources for community-based housing
- More employment options

What Housing Barriers?

- Affordability
- Poor coordination of housing and service funders
- Felony convictions
- Release from jail and hospital
- Bad credit histories
- Cultural and language barriers
- Not enough jobs

What Housing Outcomes?

- Tenant, patient and landlord satisfaction
- Length of stay in residence
- Reduction of hospital, jail days
- Reduction in evictions
- Reduction in numbers of homeless mentally ill
- Reduction in wait time for housing
- Increased housing options to fit diverse populations

Preliminary Report Outline

I. Definition of Housing Action Plan

II. Summary of Data Collected

III. Key Findings from Washington
   A. System strengths
   B. System gaps/weaknesses
   C. Estimate of housing needs

IV. Best practices nationally

IV. Preliminary Report

A. Housing Philosophy

B Models

C. Partnerships

D. Financing Strategies

E. MHD and RSN roles

F. Capacity building

Housing Action Plan Content

- Range of housing options
- Housing unit goals
- Policy requirements
- Resource requirements
- Local capacity building requirements
- Schedule for first 500 units

Questions

- What are the two most important steps that the **State MHD** could take to assure more appropriate affordable housing for people with serious and persistent mental illness?
- Two most important steps for **RSNs?**
- Two most important steps for **mental health providers?**
- Two most important steps for **consumers?**

Questions (cont'd)

- What types of housing are appropriate for people with serious and persistent mental illnesses?

- What types of housing are less appropriate for people with serious and persistent mental illness?

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Washington State System Transformation Initiative

Update on Mental Health Benefits Design Project

Andrew Keller, PhD

January 16, 2007

Perspective on Project: Medicaid Trends

- Need to factor in current Medicaid funding context
  - ✓ Implications of 1997 BBA, 2005 Deficit Reduction Act
  - ✓ Issues for 1915(b)(3) states (WA, CO, CT, FL, NM, PA, UT)
  - ✓ Issues with recent State Plan Amendments
- Need to address Medicaid State Plan and Implementation
- Medicaid State Plan versus State Regulation
  - ✓ Goal of Medicaid State Plan is to maximize FFP
  - ✓ Goal of State Regulation is to implement benefits
  - ✓ Examples of Arizona, Massachusetts, Pennsylvania

Three States' Approaches to Optional Rehabilitative Services

- Benefits are defined in the "Limitations" section of Medicaid State Plan
- Pennsylvania developed their definitions pre-managed care
  - ✓ Detailed definitions of two types of service in 2004: Crisis Intervention and Family Based Mental Health Services
  - ✓ Trying now to add Peer Support and Mobile Therapy
  - ✓ Most services are under 1915(b) Waiver
- Arizona developed their limitation post-managed care – here is the total text of the limitations in their plan:

  Rehabilitative Services provided by a behavioral health and/or substance abuse rehabilitation agency.
- Massachusetts: No limitations
- What do AZ and MA do? They manage by state-level regulation

Initial Analysis of Input from November Community Forum

- No service gaps were noted that seemed outside of current State Medicaid Plan – Top services included:
  - ✓ Peer support
  - ✓ Psychoeducation
  - ✓ Medication management
  - ✓ Supported employment / employment supports
  - ✓ Inpatient and crisis services
  - ✓ High intensity services
- Also interest in broader supports outside of Medicaid
  - ✓ Housing supports was #1
  - ✓ Easier eligibility requirements for Medicaid

Initial Analysis of Input from November Community Forum

- Issue more "how" services are used, not "what" services are used
  - ✓ Peer support by peer-run organizations, not CMHAs
  - ✓ Broader access to full array of needed services
  - ✓ Early intervention
  - ✓ Better linkages to natural supports
  - ✓ Integrated medical and mental health services
  - ✓ Integrated substance abuse and mental health services
  - ✓ Self-directed care
  - ✓ Broad array of consumer/family-driven supports

Perspective on Project: Evidence-Based Practices

- Paper will give overview of key EBPs & Promising Practices, including implementation issues involving cross-cultural applications
  - ✓ Adult EBPs – ACT, IDDT, DBT, SE, Family Psychoeducation, Gatekeeper, MedMAP
  - ✓ Child EBPs – FFT, MST, MTFC
  - ✓ Recovery/Resilience-focused – Wraparound, WRAP Planning, School-based, Peer Support, Clubhouse, Primary Care Integration
- Evidence-based programs vs. practices vs. culture
  - ✓ Difference between evidence-based programs versus practices
  - ✓ National focus has shifted to evidence-based culture
  - ✓ Tension between EBPs and recovery/resiliency practices
  - ✓ Tension between EBPs and cultural competency

Evidence-Based Culture

- Current research on EBP implementation: "Evidence-based Culture"
  - ✓ Dixon (2003), Barwick et al (2005), Rivard et al (2006)
  - ✓ Recognizes the need for system/organizational infrastructure to support the implementation and broad dissemination of evidence-based practices
- Key components include:
  - ✓ Involves all levels of the system – state, regional, managers, clinicians
  - ✓ Begins a thorough understanding of the current treatment system
  - ✓ Systematic approach to review available evidence, recommend changes
  - ✓ Supports a reimbursement rate commensurate with implementation
  - ✓ Provides reimbursement for needed training and clinical supervision
  - ✓ Data collection and reporting mechanisms to document EBP results

Evidence-Based Culture (continued)

- Key components (continued):
  - ✓ Develops policies to facilitate adoption/implementation of EBPs
  - ✓ Bi-directional communication between researchers and clinicians
  - ✓ Appropriate balance between fidelity and adaptation
  - ✓ Uses outcome data to drive systems change

- This research specifically shows that simply requiring EBPs hasn't worked and may in fact be counter-productive
  - ✓ PACT development and implementation is good example of what works

Evidence Based Programs Versus Practices

- An evidence-based culture allows for differentiation between evidence-based programs and practices
  - ✓ The focus of most public sector efforts have been self-contained **programs**
  - ✓ However, most people receive services through **practices** embedded in traditional services (case management, individual treatment)
- Examples
  - ✓ Integrated Dual Disorder Treatment – 14 components, each with evidence
  - ✓ Hawkins and Catalano (1992) – 7 elements based on evidence
- Both are needed – recent Children's MH EBP Pilot is good example

Tension Between EBP and Consumer/Family Driven Practices

- Current transformation efforts often lead to tension between EBPs and Consumer/Family Driven Practices
  - ✓ Personal Assistance in Community Existence (PACE) – Dan Fisher, PhD
  - ✓ If the is choice between PACT and Peer Support, guess which wins?
  - ✓ But the research shows the choice is between PACT and jail/hospital/street
- We see the two separate dimensions which can be applied to any practice
  - ✓ What is the degree of evidence of the practice?
  - ✓ How consumer/family driven is the practice?
- On the next page is an example based on the MHTG input of priority services – THIS IS AN EXAMPLE ONLY – this will be revised as we complete our literature summary

SAMPLE TABLE – For Illustration Purposes Only

Evidence→ Consumer/Family Driven ↓	EBP	Promising Practice / Emerging Evidence	Minimal Current Evidence	Evidence of No Benefit or Risk
Consumer/Family Run and Operated		▪ Clubhouse ▪ Attending Support Groups ▪ Social Supports / Community Connections / Natural Supports	▪ Warm Lines by Consumer Organization ▪ Involvement in Advocacy ▪ Drop-In Center	
Consumer/Family Operated	▪ Family Psychoeducation by Families	▪ Wraparound Planning facilitated by Parents ▪ WRAP Planning by Consumers ▪ Receive / Give Peer Support ▪ Parent Partners ▪ Youth as Mentors	▪ Warm Lines by MH Center	
Consumer/Family Involvement	▪ Learning Self-Help Strategies (IMR) ▪ Supported Employment	▪ Wraparound Planning facilitated by Professionals ▪ Supported Housing Supported Education ▪ WRAP Planning by Professionals ▪ Mentors for Youth	▪ Socialization Opportunities ▪ Other Illness / Wellness Education	
Professional Run and Operated	▪ Cognitive Behavioral Therapy (CBT) ▪ Functional Family Therapy (FFT) ▪ Medication Management (MedMAP) ▪ Dialectical Behavioral Therapy (DBT)	▪ Motivational Enhancement Therapy (MET) ▪ Crisis Lines ▪ Respite Care ▪ Some Group Therapies ▪ Some Trauma / Abuse Counseling ▪ Psychiatrist ▪ Psychologist	▪ Art Therapy ▪ Massage Therapy ▪ Acupuncture ▪ Undifferentiated Individual Treatment	▪ Undifferentiated Day Treatment ▪ Undifferentiated Group Therapies

Initial Report Outline

I. Introduction, Scope and Methods

II. Overview of Current Mental Health Best Practices
   A. Key Concepts in Implementing Best Practices
      1. Experience of States that have been successful in implementing best practices
      2. Evidence-based Culture
      3. Overlap of Evidence-Based and Consumer/Family-Driven Services
      4. Cultural Relevance
   B. Best Practices for Adults and Older Adults
   C. Best Practices for Children and Families

Initial Report Outline (Continued)

III. Analysis of Washington State's Medicaid State Plan

A. Overview of the Medicaid State Plan and Managed Mental Health Care System

B. Comparison to other States: Arizona, Colorado, New Mexico, and Pennsylvania

1. Benefit Design
2. Organization of Managed Care System

C. Ability of Each State's Plan and System to Support Best Practices

1. For Adults and Older Adults
2. For Children and Families

D. Cross-Cutting Issues

1. Satisfying federal "statewideness" requirements
2. Going beyond "statewideness" to ensure adequate access to needed services statewide
3. System changes that may be needed to support best practices
4. Other issues

Initial Report Outline (Continued)

IV. Washington State Stakeholder Concerns Related to Benefit Design
- A. Overview of Stakeholder Input from December Forum
- B. Key Issues Related to Financing and Delivering Best Practices

V. Preliminary Recommendations and Next Steps
- A. Possible Areas of Recommendation Based on Initial Findings
- B. Next Steps
  1. Developing Recommendations with Stakeholder Input
  2. Approach to Developing Cost Analysis of Recommended Benefit Changes
  3. Identifying Implications for RSN Rates and Provider Fees
  4. Developing an Implementation Plan and Time Line

Questions

- 1. What is your reaction to the benefit package update?
- 2. Do you have any advice or recommendations for the consultant?

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